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network

SMMGP SUBSTANCE MISUSE MANAGEMENT IN GENERAL PRACTICE

A national newsletter on substance misuse management in primary care

Methadone maintenance prescribing - how to get the best results

Dr Jenny Keen, *Clinical Director of the Primary Care Clinic for Drug Dependence in Sheffield, and Clinical Research Fellow at the Institute of General Practice and Primary Care at the University of Sheffield*

When we consider the practical use of the evidence on methadone maintenance we must be clear about exactly what we are trying to achieve. Ward et al (1) make the point that "...it is unfortunate that the success of methadone maintenance treatment continues to be judged by what happens when it is discontinued". The primary aim of methadone maintenance treatment is *not* to produce abstinence, and indeed there is no evidence that any treatment can reliably produce this outcome in the long-term. The evidence for methadone maintenance treatment is about *improving quality of life whilst the patient is actually in treatment* and not necessarily when treatment is discontinued, although there is no evidence that methadone maintenance treatment actually increases the length of opiate dependence (2). The outcomes that we can expect to achieve with methadone maintenance are therefore about in-treatment harm reduction.

Harm reduction outcomes

Success in reducing drug-related harm has been shown since the earliest studies of methadone maintenance treatment and across a very wide range of settings, services and clinical backgrounds (1,2,3,4,5). Findings have held good even in relatively small studies because in general the effect size of the intervention is so large. Across the board, studies have found very large reductions in illicit drug use, major improvements in physical and mental health, better social adjustment and markedly less involvement in criminal activity when patients are treated with methadone maintenance. It is likely that the spread of blood-borne viruses may also be reduced by this intervention. Methadone maintenance treatment also has a major impact on reducing heroin-related deaths (6). Once again, however, it is important to emphasise that these are in-treatment outcomes and there is no good evidence to suggest that they persist after treatment has discontinued.

How to optimise outcomes

The key to optimising outcomes seems to be to focus on the goal of maintenance as acceptable in its own right, rather than treating it merely as a stepping-stone to abstinence. With this in mind, *retaining patients in treatment* takes on a high level of importance, and a number of studies have associated successful outcomes with services that succeed in retaining patients for longer periods (4,7). Retention in treatment is linked with *prescribing adequate dosages of methadone* (8), and in fact a prescription of adequate dosages has been shown time and again to be a key factor in producing good harm reduction outcomes (1,2,3,9). Given the enormous variation in individual rates of metabolism of methadone (10), patients may well be the best judge of what dose of methadone is required, although titration should always take place within a robust clinical governance framework that includes the option of supervised consumption of methadone. The Clinical Guidelines (11) suggest that between 60 and 120 mg of methadone daily would encompass the majority of doses required by patients on methadone maintenance treatment but there may well be individuals who require considerably more or less than this.

In addition to retention in treatment and adequate dosages, it has been shown that a *sufficient duration of treatment* is important and that harm reduction outcomes are lost if detoxification is attempted before patients are ready (12).

In summary, therefore, patients should receive treatment which is not time limited, with no arbitrary upper limit on dosages and where any move towards abstinence is driven by the patient, if best outcomes are to be achieved. *The goal should be to provide good maintenance rather than maintenance that is compromised by the goal of abstinence.*

Factors associated with poor outcomes

Methadone programmes which tend to produce poorer harm reduction outcomes are those which offer time-limited treatment, dosages which are inadequate or which are reduced before the patient wishes to do so, and those which focus on administrative processes and keeping control rather than on a supportive and empathic approach (1,13). Low quality medical and psychosocial services, where staff are poorly trained or have negative attitudes towards drug users, and programmes not oriented towards social rehabilitation, also seem to produce poorer outcomes.

Selecting patients for methadone maintenance

Programme variables appear to be far more significant in affecting outcomes than patient variables according to the available evidence. Poor prognostic indicators for patients at entry include poor mental health, poly-drug use and diversion of prescribed medication. On the other hand these are the sorts of problems that over time *may well be alleviated by the very treatment from which we might otherwise seek to exclude these individuals.* For this reason the leading reviewers in the field (1,3) tend to conclude that, within very broad parameters, the selection of some patients for methadone maintenance treatment and exclusion of others on the basis of prognostic indicators are probably unjustified.

Paradoxically, those patients most likely to die from heroin-related causes are untreated, older injecting drug users, who may have been using opiates for many years alongside a number of other drugs and who may have complex psychosocial needs. These patients, who may be low waiting list priority compared with younger users seeking detoxification, may be the ones for whom harm reduction, especially in terms of heroin mortality, may be the most marked when they enter treatment (6,14).

Prevention of deaths

Methadone maintenance treatment has been shown to be a major factor in reducing heroin-related deaths (6,14), and there is some evidence that *this can be achieved without producing a concurrent rise in methadone deaths* (15) where careful clinical governance structures are in place. There is, however, no available evidence to show which elements are essential in order to minimise methadone-related mortality without compromising the acceptability of the programme and thereby losing patients to treatment. It seems likely that supervised dispensing can play a part in maintaining safety (2,15,16) but this needs to be used appropriately so that patients are not discouraged from persisting in treatment, with the subsequent loss of harm reduction outcomes.

The National Guidelines (11) provide some guidance on the reasonable use of supervised consumption. Avoiding large take-home doses and infrequent pick-ups would seem to be sensible safety precautions, and maintaining a high level of patient awareness of risks to children and the potential risk of loss of tolerance must surely feature in a safety-conscious programme. There is some evidence that regular urinalysis can contribute to reducing illicit drug use (17) but conversely there is evidence that patients tend to tell the truth about illicit drug use as long as there are no punitive sanctions as a result (1,15). There can be no doubt that *it is entirely counterproductive to exclude patients from treatment simply on the basis that they have not achieved abstinence from all illicit drug use.* Indeed, some patients may achieve good harm reduction outcomes in other areas whilst continuing to use some illicit drugs.

Illicit drug use may, however, be a marker of instability. This can suggest a need for higher methadone dosages or for a return to supervised consumption of prescribed medication. In this situation regular urine samples can be a useful tool.

The effect of dosages

There is evidence that within certain limits many patients can safely determine their own dose levels and, contrary to the expectation of many doctors, will not push for the highest possible dosages (1). There is also evidence that higher doses tend to more effective (2,9) and that flexible dosing contributes to retaining patients in treatment. Within careful parameters, and making full use of daily dispensing and supervised consumption where appropriate, *'ceiling' dose levels are probably best avoided.* Patients should be prescribed the amount of methadone required to abolish withdrawal symptoms and to make the patient comfortable throughout the 24 hours before the next dose. Specialist advice and support should be sought if the GP feels uncomfortable with the doses required.

Case management

Without doubt methadone maintenance treatment is a very powerful tool for the achievement of harm reduction outcomes, even when it is delivered where there are relatively few support services. However, there is evidence to suggest that the outcomes of methadone maintenance treatment can be further enhanced by various types of case management interventions, and that goal-oriented wraparound psychosocial services support good outcomes (18,19). *The best evidence appears to be for mixed psychosocial interventions,* whereas outright psychotherapy appears to help people with specific psychiatric problems but has not been shown to be effective for other drug users (1). Looked at from the point of cost-effectiveness, it appears that moderate levels of psychosocial support produce the best value for money in terms of helping methadone maintenance patients not to use illicit drugs; there may be a diminishing return when more intensive input is offered. Whatever type of case working or psychosocial support is offered, it should be optional. Mandatory attendance at case working or counselling sessions does not produce better outcomes (1).

How to retain people in treatment

In view of the importance of retention in treatment for delivery of high quality outcomes, Ward et al (1) reviewed what features and services appeared to encourage patients to stay in treatment. These were: long-term rather than short-term treatment philosophy; accessibility and convenience; availability of ancillary services; optional case working and psychosocial support; willingness to prescribe higher methadone doses; and availability of take-home doses. This would seem to reflect the sort of service characteristics which would affect attendance and retention in any treatment service, not just services for drug users, i.e. offering the correct treatment with suitable support services in the most user-friendly environment possible.

Conclusion

Ward et al (2) conclude their 1999 *Lancet* review of maintenance treatment as follows: "The most effective programmes are those that provide higher doses of methadone as part of a comprehensive treatment programme with maintenance rather than abstinence as the treatment goal". It is not enough simply to bring patients into treatment: we owe it to them to provide this treatment in the most effective way possible (20,21).

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Substance misuse services in Gateshead: Paul Stanley

In the October issue of Network, a Gateshead GP, Dr Paul Cassidy, described the rapid rise in GPs prescribing methadone. In this issue, Paul Stanley, a service manager at Twenty Four:7, describes a shared care scheme that currently involves 80 per cent of the GPs

In October 2000, the service provision for drug users in Gateshead took a giant step forward. The integration of the statutory Health and Social Services Drug and Alcohol Teams created Twenty Four:7, a multidisciplinary team managed in primary care. Over its short lifespan, Twenty Four:7 has boldly tackled the major issues facing drug treatment services in Gateshead in partnership with other agencies. The two most significant achievements are the reduction in waiting time from six months to six weeks, and the involvement through the shared care scheme of 80 per cent of Gateshead GPs.

Relationships with GPs crucial to success

So what makes Gateshead special and why do we have such a successful shared care scheme? Our greatest strength is the relationship we have built with GPs. We have worked hard over the last six years to earn their trust by developing a robust framework and effective protocols to provide a service people feel confident referring to. Working in the community, everyone is seen in primary care, and without the option of a central prescriber, the links with GPs have become particularly strong. This has been further bolstered by the adoption of models of good practice from elsewhere in the country.

It has not been an easy process as there have been a number of significant issues that have affected how we work with drug users, reflected in national and local policies and the introduction of the 1999 Guidelines. Our willingness to support GPs working with drug users ensures that GPs are not facing the pressures of working in isolation. We provide a continuing education and training programme on subjects such as methadone prescribing, dosage levels and benzodiazepine prescribing. The attendance of GPs at regular training meetings, where good-practice is shared, helps to maintain a high level of inter-action. We also ran a highly successful conference on shared care in January 2003, which celebrated the effectiveness of inter-agency work since the shared care scheme began.

Adaptive and flexible to users' needs

Shared care has proved to be both a popular and effective method of managing methadone treatment programmes for illicit drug users. The range of treatment options open to service users is developing, taking in treatments such as methadone maintenance, lofexidine, buprenorphine and naltrexone. Additionally, the involvement of service users in Twenty Four:7, and their input into shared care, help to define the shape of the scheme and contribute to its effectiveness, for example, the gathering of service user views on supervised consumption, and the development of a specialist service for stimulant users.

Pharmacist participation and partner agencies

Other areas of success include the increasing, and active, participation of pharmacists, and a proactive supervised consumption scheme. Pharmacists have become an integral part of shared care and are a valuable resource not to be overlooked. A wide range of work with partner agencies, such as the North East Council on Addictions, Turning Point Arrest Referral Team, and the Probation Service, is undertaken within Gateshead. A shared care Monitoring Group was set up 18 months ago. It is well attended by representatives from treatment providers, pharmacists, commissioners and service users. Everyone has a degree of ownership, a voice, and has a vested interest in making the system work.

Challenges to be faced

Shared care in Gateshead does have areas that need improvement. These include the plight of homeless drug users without GPs, a drive for more consistent practice across a wide-range of professionals and agencies, and how we can better respond to the needs of poly-drug users who present with crack-cocaine problems.

To address these areas two new appointments have been made at Twenty Four:7. A specialist GP has been employed to lead on developing the medical input into shared care and support GPs currently prescribing in Gateshead. An H grade nurse is to take forward the development of the shared care scheme.

Exciting times ahead

We are aware that our service is 'work in progress', and that we are by no means the finished article. But what we do know is that for the first time there is a real interest - and real money - coming into substance misuse services. The National Treatment Agency has provided the substance misuse field with an identity and a focus that has brought drug issues into the mainstream. For those of us fortunate enough to work in substance use, we are on the threshold of some very exciting times with:

- the increasing influence of user involvement;
- the potential for prescribing alternatives to methadone;
- a framework and direction that come from Models of care;
- the increasing realisation that shared care schemes are the way forward for working with substance users;
- the new GP contract and its implications for substance misuse services in general practice.

The challenge is to maintain our momentum and ensure the continued success of shared care in Gateshead.

Involving drug users – the work of The Alliance (formerly the Methadone Alliance)

Bill Nelles, *Chief Executive of The Alliance, shows how committed drug users and professionals are working together as equals to improve the quality and availability of drug treatment in the UK*

We have come a long way since debates about drug dependency were conducted without the active participation of drug users themselves. We, as users, are the people who have significant experience of the problem and valuable insights into what is helpful, and what is not helpful, to drug users. The aim of The Alliance is therefore to ensure that drug users are actively involved in the debate about their treatment and care at every level – locally, regionally and nationally.

We provide *advocacy* and *representation* to people receiving poor care, and *help improve their situation* and their experience of 'treatment'. We help resolve conflicts between treatment provider and patient. We ensure treatment provider and drug user listen to each other's concerns with respect. We challenge poor treatment with gentle but effective persuasion and education. We educate users about their rights to effective treatment so that they can take an informed role themselves in the treatment debate. The Alliance demonstrates, moreover, that drug users can be constructive and capable partners to those tasked with providing treatment services. We demonstrate from within The Alliance itself that a 'user-led' service is possible. Our four staff members are responsible to a Board of Management of nine drug users and treatment experts. We also have about ten full-time volunteers, and can draw on the help and support of a growing number of doctors and treatment providers.

One of the first things we have worked to correct is the misinformation and prejudice that still means some people who are opiate-dependent cannot get access to treatment. Bizarre though it is, this even occurs amongst specialist drug professionals - drug workers, nurses, and doctors. Too many people have been getting access to sub-standard treatment, low doses that were ineffective, months of waiting, or were unable to get the treatment at all. Rigid practices that are not patient-friendly have been all too common, practices that would not be tolerated by patients in other areas of healthcare. One example was compulsory reduction instead of open-ended maintenance. Another was punishment for relapse, with disciplinary discharge for illicit use.

We have had to remind people sometimes of the basic principles of good methadone treatment. Nowadays, the UK has a comprehensive set of clinical guidelines that strongly endorse methadone treatment. Yet there are still gaps in its effective delivery in parts of the country. Still the debate remains polarised. Contrast the following:

> "...the new method of treatment concentrates on getting an addict off the drug in a short space of time. He is then given a plan of four weeks or six months after which treatment will stop" (Banks and Waller, 1988)

> "...it is important to remember that abstinence is only one option available to the patient and that an otherwise fulfilling life while attending is another" (Ward et al, 1988)

Well, we are doing our best to demonstrate that the second of these propositions is the better medicine. Imagine what it is like to be a patient caught up in this angry and sometimes bitter debate about what to do with people who are opiate-dependent.

How we work

In a certain English town they believe that 'good' treatment for people who are opiate-dependent is a 'no-choice' detox. We started to receive telephone calls from local users who had heard that we could help to change this sad state of affairs. Our advocacy services, provided by people who understand because they have been patients themselves, contacted the users, listened to their complaints, and gave them advice and personal assistance to challenge this situation. Using our alliances with the GP network, we were able to put effective pressure on the local service providers, and the result was a complete change in that town's treatment policies. Now users there can expect to be listened to and not ignored or dismissed as sick patients who 'cannot understand'.

So what have we achieved as we approach our sixth birthday? Our finest moment last year was the successful launch of our annual conference: the UK National Drug Treatment Conference. There has never been a regular UK annual conference with this remit, and now there is. The 2004 Conference is to be in London on Thursday-Friday, 4-5 March 2004. Details are at: http://www.exchangesupplies.org/conferences/UKNDTC-2/

We intend to broaden the scope of our work in the immediate future. There will be more written information to back up our face-to-face and telephone work. We will be monitoring Drug Action Teams to ensure that they are following the National Treatment Plan for user involvement. We will ensure that every locality has a full range of evidence-based treatments available to its residents. We will demonstrate, through the work of The Alliance and local groups, that the potential exists for users to manage such projects for themselves.

> "We must take the moralising out of the drug treatment and put the humanity back in"
>
> *Bill Nelles, in his speech at the International Harm Reduction Association 14th Conference in Chiang Mai, Thailand, April 2003*

There are many places where drug policy may go in the future. But we can no longer be in any doubt that methadone treatment is a valuable and essential part of a rational response to opiate dependency.

Note

The Alliance web site is at: www.m-alliance.org.uk

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Drug users now actively involved in the RCGP certificate course

It is very exciting that the RCGP course has been opened up to include current, and former, patients in treatment. This year, 12 people - all of whom are engaged in some form of user advocacy - are training as 'expert' patients alongside the doctors, nurses and pharmacists traditionally involved. "We had no problems filling the places - people were thrilled at the opportunity to study drug treatment in such depth", said Bill Nelles, Director of The Alliance. The patients are studying the same material as their medical colleagues, with the observation and interactive work tailored to their work as expert patients and treatment advocates. Before the first class, some people feared that the course might be too demanding, but everyone is well supported and found the first class stimulating and enjoyable. "Before the course I felt that doctors were a bit of a law unto themselves but now I realise that there have to be some clinical guidelines to ensure safety of the patient and the doctor" said Nigel Munro, an Alliance volunteer. "This has given me the knowledge I needed to become a more effective advocate."

Why such contrasts between different DTTO schemes? A time for re-evaluation?

Dr Linda Harris, *GP and Mental Health Lead, Wakefield West PCT; Mentor for the RCGP Certificate course in Primary Care Substance Misuse*

Dr Chris Ford, *GP and GP Advisor to SMMGP*

Many of us would prefer if the DTTOs (Drug Treatment Testing Orders) had never been dreamed up, but they have and it seems like they are here to stay, although the evidence is either slim or mixed on both sides! (see Alex Stevens in Druglink, Jan/Feb 2004, pp.10-11). Why was the decision to increase the DTTO programme taken before the evaluations of the pilots took place? If we know voluntary treatment works, both in improvement of health and reduction in crime, are DTTOs a sensible way forward?

But if they are here, can we make the best of them? There have been two reports recently with markedly different results: one about the effectiveness of DTTOs in London (Best et al, 2003) and the other evaluating the Scottish DTTO pilots (Eley et al, 2002).

- The London paper showed at four months that over half the offenders did not understand what they had agreed to and a quarter were back in custody and had had their orders revoked. Non-compliance had led to the court revoking the DTTOs. Most of the teams seemed to be poorly managed and there was no consistency in whether tests were used as a therapeutic or a disciplinary tool.
- In the Scottish paper very few of the DTTOs (3 out of 96) were revoked, and the offenders seemed to be getting to the people for whom they were intended.

In general in England and Wales 69 per cent of DTTOs were revoked because the offender was convicted or did not comply with the order. In Scotland just one-fifth of offenders are reported to the courts for breaching their orders, and even fewer have had their orders revoked.

But defining impact and success for offenders on the DTTO is not straightforward due in the main to the fact that the DTTO exists in a relatively open policy environment concerning delivery. So whilst there are national standards for the probation service regarding the administration of these orders there are no equivalent standards for treatment providers.

Treatment interventions are delivered within a framework of twice weekly drug testing and the number of hours that a service user should be actively engaged in treatment (26 hours per week for the first 12 weeks reducing to 12 hours for the remainder of the order). This has inevitably led to a variety of interventions being provided for a range of offenders' needs and a significant variation across the country in both the content and structure of treatment programmes.

Furthermore, whilst commissioners advocate equity of access, choice and quality of care between criminal justice and non-coercive treatment programmes, feedback from service users and carers paints a picture of new investment being targeted, at a local level, at those services that provide rapid access to prescribing for the most prolific offenders.

The overarching aim of DTTOs is the reduction of drug misuse and drug-related offending but practitioners working in the criminal justice field recognise that a range of other factors often take priority in the process of working towards eventual subsistence from drugs. For example, improved health and job prospects, gaining stable drug-free accommodation and dealing with other social and personal issues may well be taken as proxy indicators of reductions in drug misuse and crime.

Encouragingly research is now emerging that fosters a more open and honest debate on the efficacy of DTTOs than practitioners have had access to in the past. For example, research commissioned by the National Probation Service in West Yorkshire on their DTTO programmes (Turner, 2003) utilises validated ways of measuring dependency (the Leeds Dependence Questionnaire: Raistrick et al, 1994) and health and health risk behaviours (Maudsley Addiction Profile) as well as looking at the users' employment, financial, accommodation and social situations and capturing offenders' views of the order.

Research of this type helps dispel the myth that rapid access to prescribing in order to break the link between drugs and crime automatically leads to sustained engagement with services and sustained change. For example, an offender who reduces their drug spend from £200 a week to zero may still present a whole range of pressing social problems. Clearly both reducing drugs and improving offenders' social situation need to be addressed, along with other needs, but it cannot be said that drug use should be addressed in isolation of social issues.

So how can we do more to improve the efficacy of DTTOs as they take their place amongst an ever-expanding range of criminal justice intervention programmes? It is clear that some programmes seem to achieve 'better outcomes'. But are we comparing 'apples with pears', given the extent of the variation in treatment modalities offered by different services and the recognition that DTTO teams do experience service problems to a greater or lesser extent.

Most generalists are aware of the Government's emphasis on crime-busting treatment interventions and will have experience of some of their patients being on a DTTO at some time. Are we satisfied that generalists are kept informed of the progress of their patients and are aware of the shift in emphasis of co-ercive treatment models away from bio-psychosocial outcomes and towards rapid access to prescribing and decreased self-reported drugs spend and crime committed?

Does national policy need to change to reduce failure rate and recidivism? Do more realistic standards need to be set with a greater emphasis placed on harm reduction to both the offender and to the public in discussion with all DTTO stakeholders? There is a sense of a message needing to be shared with community practitioners, GPs and clinical governance leads of the PCTs around how to avoid a two-tier system of access to services - potentially destructive if you work in a service committed to integrated care pathways.

Finally, if DTTOs are going to continue, we certainly need more understanding and research into the reason behind the high failure rates. Commissioners should be accessing local

experiential and qualitative data on the impact of local DTTOs and what outcomes are expected to feed into the DAT treatment plan.

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Turner R (2003) The Impact of Drug Treatment and Testing Orders in Yorkshire: Six Month Outcomes. West Yorkshire: National Probation Office.

Notes Chris Ford: Should we be trying to improve DTTOs and other elements of the CJS or making a firm stand against the Government's position on drugs, away from health towards the CJS? Let's hear your views, and join the discussion on the SMMGP website: www.smmgp.co.uk

Does a DTTO interfere with a patient's pre-existing treatment? Can arrangements be made for a seamless transfer of the client's care plan? See Dr Fixit on page 7.

Paper review

Leavitt SB (2003) ***Methadone dosage and safety in the treatment of opioid addiction.***
Addiction Treatment Forum On-line

This excellent synopsis of the evidence tells you all you need to know in the safe prescribing of methadone. It emphasises the need to have dosages set to the needs of the individual and not within artificial caps. The science behind the need for wide range of dosages is clearly explained and, within this, an explanation of when doses may need to be split. Whilst the author explains clearly the need for caution during induction - when patients are 98 times more likely to die than when stable (US figures) - it also emphasises the need to reach an adequate dose, clearly linking adequate dosing to patient safety in terms of both mortality and other harm. There was a memorable quote from Dr Vincent Dole in this section: "There is no compelling reason for prescribing doses that are only marginally adequate. As with antibiotics, the prudent policy is to give enough medication to ensure success" (Dole, 1988). The paper emphasises that measuring serum methadone levels is a useful but not foolproof method of ascertaining the need for high or split doses. Essential reading for those making clinical decisions about dosage.

– Review by Jim Barnard, SMMGP Advisor

Beich A, Thorsen T and Rollnick (2003) ***Screening in brief intervention trials targeting excessive drinkers in general practice: systematic review and meta-analysis.*** **British Medical Journal, 327: 536-42.**

This study questions the effectiveness of screening in general practice to locate patients who consume excessive amounts of alcohol, and who can then benefit from brief interventions that enable them to change their drinking to within sensible limits. Beich et al conducted a meta-analysis of eight studies that evaluated screening as a precursor for brief interventions. They found that the number needing to be screened per success, and the workload involved, are impracticably high if the available evidence is transferred into daily practice. The authors conclude that if a practitioner:

- screens 1000 patients,
- carries out a further assessment in 90 patients who screen positive,
- gives feedback, information and advice to 25 who qualify for brief intervention,
- then only two to three patients can be expected to benefit in terms of changing their alcohol consumption to within safe limits.

Noting that the general practitioner might find the exercise disappointing, the authors question the model of universal screening and say that research should focus on other ways of addressing excessive drinking.

This paper generated widespread criticism, both within the BMJ and in the instant responses on the BMJ website.

This has been followed closely by Alcohol Concern, where Richard Phillips,
Director of Policy and Services, says:

"A consensus is emerging that Beich et al's paper is actually flawed. The conclusions that these authors reach are not supported by the evidence they present. Most of the researchers whose papers are included in this review are themselves heavily critical of the methodology that has been used in the review. It surprises us that the paper was published in BMJ."

"One of the criticisms of this review is that it ignored the possibility of selective screening, which is the approach to screening that most of the authors of the eight research papers now recommend. This means targeted screening upon presentation of symptoms or conditions that are strongly correlated with alcohol misuse, and at that point screening is carried out. The evidence base for effectiveness and cost effectiveness of targeted screening is actually very strong."

"GPs have a central role to play in the implementation of the National Alcohol Harm Reduction Strategy. They are the ones who see the 8 million plus people in this country who are coming to harm because of hazardous drinking but do not present to specialist services. Primary care presents an absolutely key opportunity to intervene to reduce binge drinking and hazardous drinking."

For further information on the Beich et al paper controversy, see
www.alcoholconcern.org.uk/servlets/searchsite/search?search=Beich

– Review by Maggie Pettifer, SMMGP Managing Editor

Dr Fixit - getting the dose right

Dear Dr Fixit

I have a patient, John, who is doing very well since he came into treatment. He is 34 years old and lives with his partner, a non-user, and their children of 6 and 8 years. Since starting treatment his health has improved and he has not been arrested for several months. He is on methadone 60 ml daily and he has asked for an increase. Previously he was reluctant to go above 60 ml but he says it is getting more difficult on this dose and recently he has had to use heroin to avoid withdrawals. I know the evidence of best maintenance doses are between 60 and 120 mg but the local shared care scheme are unhappy for us to prescribe above 60 ml. How can I help this man?

Answer by Dr Charlie Lowe, *PCT Lead for Substance Misuse Services, Plymouth PCT*

Clearly John has done very well and needs reminding of this. A dose increase is not out of the question but first you want to know much more about his use on top. Has he ever managed to stay just on his script? What time does he take his methadone? There is a ten-fold difference in metabolic rate between clients so some benefit from a small bedtime dose to avoid withdrawals in the early hours. What are the triggers to his use? The details are vital and unique to each user. The three 'Horseman of Relapse' are boredom, arguments and peer group pressure, so check these out and look at new strategies other than relying on that great emotional analgesic - heroin.

Remember to scan for harm reduction generally - needle exchange, risk of BBV, injection sites, crime to fund habit and so on. Ask about other substances, especially Valium and alcohol, as these in combination with methadone often feature in the coroner's toxicology reports.

Also always check the patient is not taking any other drugs, such as disulfiram, phenytoin or rifampicin, which could be causing changes in the elimination of methadone.

Your patient will often have a view about the right dose of methadone they need, and typically increments of 5 or 10 ml are given. Urine screening in advance, and then as the dose is increased, is worthwhile. Also, while changes occur, a period of supervised consumption is safe practice. The Clinical Guidelines suggests three months of supervision for new scripts so in this case it would be a clinical judgement, weighing up the whole situation.

The research base for adequate, often incorrectly described as higher, doses of methadone is well established, and cautious (non-evidence-based) guidelines may render treatments sub-therapeutic. In Plymouth, a recent survey of GP prescribing revealed a mean daily dose of 43 ml ranging from 10 to 100 ml (n=231). My principle is that the right dose is the one that retains the patient in treatment and enables positive lifestyle changes. Clearly less experienced GPs need the support of other clinicians, including GPwSI, to help build their skills. Advice has to be readily available to guide this process following appropriate training.

My final comment relates to the great difficulty some patients have in telling you that things are not working out, especially after a period of doing well. They may suffer feelings of shame at letting others down and be seriously worried that you will stop their script if you find out. It is helpful to explain early on that you will be understanding and not reject them. Indeed, their honesty and openness will be valued as you build a therapeutic relationship together. When patients can discuss use on top with you, this is a sign of trust and shows a willingness to consider change with the potential for important health and social gains.

Dr Fixit - DTTOs and treatment continuity

Dear Dr Fixit

My patient, Carl, who is 27 years old, was recently found guilty of a crime, which he undertook before he was in treatment with me. He has been given a DTTO. He has been doing well and is nervous that this is going to interfere with his treatment. He is keen not to have his treatment changed. What exactly is a DTTO and will I be able to continue prescribing his 20 mg of buprenorphine?

Answer by Dr Linda Harris, *GP and Mental Health Lead Wakefield West PCT, and Mentor for the RCGP Certificate course in Primary Care Substance Misuse*

A Drug Treatment and Testing Order (DTTO) is a probation order with a condition of treatment, and it can be applied either by magistrates or the crown court. Whilst Carl needs to volunteer to participate in the order, once he is sentenced to a DTTO then the treatment model applied is one that can be best described as 'semi-coercive'. What this means is that information directly related to the monitoring of Carl's care plan is shared with the criminal justice agencies that are involved with his care. This information influences further treatment planning and is fed back to the courts as evidence of Carl's progress.

In most cases Drug Treatment and Testing Orders are administered by the treatment team who work in partnership with the probation staff. The order requires your patient to attend for drug testing twice weekly and to engage with various treatment and probation interventions for 20 hours for the first 3 months of the order. After 12 weeks the number of hours is reduced to 12. Examples of structured interventions delivered by DTTO teams include counselling, group work, complementary therapies, clinical time, as well as programmes such as enhanced thinking skills courses, IT courses, etc.

In the case of your patient, who you describe is already stable and doing well on a treatment programme where he is being prescribed buprenorphine, then once the court sentences him to a DTTO, contact should be made between the DTTO team with his current treatment provider so that arrangements can be made for seamless transfer of the client's care plan. In some cases a DTTO team will work with the client's existing treatment prescriber who will then support the DTTO programme by continuing to manage the prescribing with regular updates from the team to the prescriber.

In my personal experience, some of the best functioning DTTO teams have dedicated prescriber support. This provides a number of benefits to the team, for example continuity of care, enhanced communication between team members, joint care planning, and overall improved retention rates. DTTO teams are strengthened when there is demonstrative joint working between treatment providers, GPs, and the probation staff. The essence of a DTTO is a programme that breaks the link between drugs and crime. The most successful way to do this is to ensure that a client is stable on a substitute prescription and receiving the holistic support that is needed to help rebuild a drug-free, crime-free life.

Bulletin Board

9th National Conference: RCGP Management of Drug Users in General Practice - Cardiff City Hall, Cardiff, Thursday & Friday, 20 & 21 May 2004. This two-day conference is the platform for the on-going debate on managing drug users in general practice. Primary care focussed, and multi-disciplinary in philosophy, this conference has become an essential focal point for GPs, shared-care workers, specialists and drug-users to come together to promote and examine current debates and models of best practice for management of drug users. Last year the conference attracted over 330 delegates – and was fully booked months before – so you are advised to ***book right away to be sure of a place***. Just fill in the enclosed form, or email your details to charlotte:healthcare-events.co.uk

Hot Topics

Global political commitment and joined up strategies on HIV/AIDS and injecting drug use are vital, says the Warsaw Declaration

Although well-evidenced, cost-effective harm reduction strategies exist in many countries it is often a case of 'too little, too late'. Ways to harmonise drug policies and strategies with HIV/AIDS policies, and gain sustained commitment from government agencies, research bodies and professional organisations, and involvement of people living with HIV/AIDS and injecting drug users, are described in the Warsaw Declaration. More information from : www.smmgp.co.uk

Drug-related deaths up 5 per cent from 2002-2003

The latest figures in the national programme of substance abuse deaths (NP-SAD) report released by St George's Hospital Medical School suggest drug related deaths are up five per cent on 2002 figures. Where a single substance was implicated in the deaths, amphetamines were responsible for an extra 28 per cent and ecstasy-type deaths were up 21 per cent, whilst cocaine was implicated in 18 per cent more deaths in 2003 than 2002. The report also highlights a general increase in poly-drug deaths, stating, "Deaths often involve a mixture of substances used in combination with alcohol". The highest annual drug-related deaths were recorded in Brighton and Hove, followed by East Lancashire. Full report at: www.sghms.ac.uk

Important change in law makes providing clean equipment legal but who is going to fund this?

You will remember that we asked you in Network to write to the Home Office to support the call for changes in the paraphernalia laws. Well this has now happened and it is now legal to distribute clean paraphernalia. You, doctors, drug workers, your local needle exchanges, pharmacies and everybody can now legally distribute sterile water, filters, citric or ascorbic acid, sterile spoons / cups and swabs, alongside needles and syringes. But there is a downside. Most needle exchanges say they do not have funds to supply the extra equipment and most say they want to encourage provision but do not have the resources. There has been no planning by the DOH, the NTA or DATs to provide the funds needed...short sightedness?

Hepatitis C Treatment Guidelines

The updated NICE Guidelines on *The Clinical and Cost Effectiveness of Pegylated Interferon Alpha 2a and Alpha 2b for Hepatitis* C have now been published and approve this treatment for use on the NHS. More information from: www.nice.org Previous guidance on hepatitis C from NICE was unclear with regard to drug users. Dr Carola Sander, hepatitis lead on the RCGP Sex, Drugs & HIV Task Group states: "This paper represents the gold standard of drug treatment based on the strong evidence currently available. GPs are often the first point of contact for people who might be infected with hepatitis C, and it is important to have the most up-to-date information to advise people appropriately prior to testing. We are pleased that the guidance explicitly includes drug users as a group who should also be offered the same treatment as other patients infected with the hepatitis C virus. With up to 400, 000 people in the UK estimated to be infected with hepatitis C, an awareness campaign is urgently needed to inform the public and to encourage testing of at risk patients, without discrimination, after appropriate discussion and assessment. An updated proforma on hepatitis C testing for use in primary care, developed by the RCGP Task Group, is now available on the SMMGP website.

Obituary

Tom Waller
(Thomas Arthur Naunton Waller)
Born 25 April 1944; died 27 November 2003

Tom Waller, a dear friend, colleague, fellow campaigner and harm reductionist, has died aged 59 years. He was a GP in Suffolk and the county specialist in substance misuse. A wonderful human being with a real sense of humanity, he started treating people with drug and alcohol problems in general practice years before it was common practice and helped to place it on the government agenda. He would keep pushing for change, never straying from his beliefs and never giving up, although the tasks were huge. I always thought of him as the father of management of drug users in general practice.

Tom really helped to put hepatitis C on the agenda. He became aware it was a condition that mainly affected people who injected drugs and therefore there was no government sympathy or funding for the infection. To challenge this position he started Action on Hepatitis C to campaign for better hepatitis C care and treatment. He was also a founding director of the UK Harm Reduction Alliance and never missed an opportunity to push the health agenda forward.

He fought against the Government's short-sighted emphasis on crime reduction and believed passionately in harm reduction. In 2001 the UK Harm Reduction Alliance established an annual award for significant contribution to the development of harm reduction policy and practice in the UK, which was named after him and mentioned in October 2003 Network.

Tom had been fighting cancer for a long time, but even this did not stop him from fighting for improved treatment. The last time I saw him was only two weeks before his death at a meeting at the RCGP about improving methadone prescribing. He joked that he might have to come back from the other side for the next meeting, but he was certainly not going to stop pushing!

I loved and was inspired by him and his passion for change, which was always coupled with the serene politeness and patience. He will be greatly missed by me and so many others in the field.

Chris Ford

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